MINNESOTA BOARD OF MEDICAL PRACTICE

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MN Relay Service for Hearing Impaired (800) 627-3529

HOSPITAL PRIVILEGES VERIFICATION

As part of the medical license application process, the Minnesota Board of Medical Practice requires that this form be completed by each hospital where the applicant has held formal privileges within the last ten years. This form must be completed by each hospital listed on the Facilities List and mailed directly by each facility to the **Minnesota Board of Medical Practice**. Any processing fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name_____ SS#_____

Signature_____ Date_____

THE HOSPITAL COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician)_____

HAD HOSPITAL PRIVILEGES AT: (Name of Hospital)_____

LOCATED AT: (Address)_____

FROM: (Month, Day, Year)_____ **TO:** (Month, Day, Year)_____

TYPE OF PRIVILEGE:_____

ANY DISCIPLINARY ACTION? Yes*_____ No_____

ANY DEROGATORY INFORMATION ON FILE? Yes*_____ No_____

Print Name_____

Signature _____

SEAL** Title _____

Date _____

Phone_____

Fax_____

*Please attach letter of explanation.
**If there is no seal, attach letter of explanation on letterhead.

01/02